

SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION
Michigan Department of Community Health

1. CONTROL NUMBER

NOTE: APPROVAL REFERS TO SERVICE AND DOES NOT GUARANTEE RECIPIENT ELIGIBILITY.

CONSULTANT USE ONLY

11. PRIOR AUTHORIZATION NO.

12. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIATL)					13. TYPE		14. ID NUMBER			15. PROVIDER USE ONLY		
16. PROVIDER'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)										17. PHONE NUMBER		
18. RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIATL)					19. SEX		20. ID NUMBER			21. BIRTH DATE		22. COUNTY
23. RECIPIENT'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)										24. DOES PATIENT RESIDE IN A NURSING CARE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. REFERRING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL)					26. TYPE		27. ID NUMBER			28. PHONE NUMBER		
29. REFERRING PHYSICIAN'S ADDRESS (NUMBER, STREET, CITY, STATE, ZIP)												

30. LINE NO.	31. DESCRIPTION OF SERVICE (INCLUDE BRAND NAME AND MODEL NUMBER WHERE APPLICABLE)	32. PROCEDURE CODE	33. QUANTITY	34. CHARGE	35. MODIFIER
01					
02					
03					
04					
05					

36. PRIMARY DIAGNOSIS DESCRIPTION AND PRESCRIPTION (QUOTE PHYSICIAN ORDER)		37. REMARKS AND/ OR DOCUMENTATION OF MEDICAL NECESSITY	

38. INDICATE ANY OTHER SERVICES PROVIDED TO THIS RECIPIENT DURING THE PAST YEAR

39. PROVIDER CERTIFICATION: The patient named above (parent if minor or authorized representative) understands the necessity to request prior approval for the services indicated in item 31. I understand the services requested herein require prior approval and if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may be prosecuted under applicable Federal or State law.

PROVIDER SIGNATURE

DATE

CONSULTANT USE ONLY

40. APPROVED AS: PRESENTED <input type="checkbox"/> AMENDED <input type="checkbox"/>		41. DISAPPROVED <input type="checkbox"/> NO ACTION <input type="checkbox"/> INSUFF. DATA <input type="checkbox"/>		42. CONSULTANT SIGNATURE		DATE	
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AUTHORITY: Title XIX of the Social Security Act
COMPLETION: Is voluntary, but is required if payment from applicable programs is sought.

MSA-1653-B (04-03) PREVIOUS EDITION MAY BE USED

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.